STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPLE		
AND PLAN	OF CORRECTION	155321	A. BUI		01	08/21/2	
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/21/2	.012
NAME OF P	ROVIDER OR SUPPLIER				STATE BLVD		
MILLER'S	S MERRY MANOR				WAYNE, IN 46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1	DATE
KUUUU							
	A Life Safety Code Recertification,		K00	000	Please accept this plan as ou	ır	
	State Licensure and Quality				credible allegation of		
		k-thru Survey were			compliance:		
		he Indiana State					
	Department of						
		h 42 CFR 483.70(a).					
	accordance wit						
	Survey Date: 0	8/21/12					
	Facility Number: 000214						
	Provider Numb						
	AIM Number:						
	7 divi i varii ber:	100207210					
	Surveyor: Amy	Kelley, Life Safety					
	Code Specialist	•					
	Code Specialist	•					
	At this Life Safe	ety Code survey,					
		Manor was found					
	not in compliar						
	= = = = = = = = = = = = = = = = = = = =	for Participation in					
	Medicare/Medi						
	Subpart 483.70						
	="	the 2000 edition of					
	the National Fi						
		FPA) 101, Life Safety					
		apter 19, Existing					
		cupancies and 410					
	IAC 16.2.	1					
	This one story	facility with a					
	walkout lower l	•					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000214

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155321	B. WIN	_		08/21/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MILLERIS	S MERRY MANOR				STATE BLVD VAYNE, IN 46815		
		THE MENT OF PREVIOUS			V/(114⊑, 114 ±0010	ı	ars)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	determined to	be of Type II (111)					
	construction a						
		he facility has a fire					
	alarm system v	·					
	detection in th	e corridors and					
	areas open to t	the corridors. Hard					
	wired smoke d	etectors are					
	installed in the	resident rooms.					
	The facility has	a capacity of 77					
	and had a cens	sus of 52 at the time					
	of this survey.						
	The facility was	s found in					
	compliance wit	th state law in					
	regard to sprin	kler coverage and					
	smoke detecto	r coverage.					
	All areas where	e the residents have					
	customary acco						
	- ·	he facility has a					
	I	ic shed used for					
	'-	lling and storage					
	which is not sp	orinklered.					
	Quality Review by	Robert Booher, Life Safety					
		edical Surveyor on 08/27/12.					
	The facility was	s found not in					
	compliance wit						
	aforementione						
		as evidenced by the					
	following:	traciica sy me					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet Page 2 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155321		(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPI 08/21					
	PROVIDER OR SUPPLIE S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 3 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155321	B. WINC		-	08/21/	2012
			\vdash	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				STATE BLVD		
MILLER'S	S MERRY MANOR				VAYNE, IN 46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018	NFPA 101						
SS=E	LIFE SAFETY CO						
		corridor openings in other slosures of vertical					
	•	r hazardous areas are					
		, such as those constructed					
		onded core wood, or					
		ng fire for at least 20					
		n sprinklered buildings are					
		esist the passage of					
		no impediment to the ors. Doors are provided					
	_	able for keeping the door					
		ors meeting 19.3.6.3.6 are					
	permitted. 19.3	_					
		prohibited by CMS					
	_	nealth care facilities.					
	Based on obser	vation and	K00	18	K018		09/20/2012
	interview, the f	acility failed to			The door to room 214 was fixed on		
	ensure 1 of 14	resident room			8/31/12.		
	corridor doors	on the 200 hall			All residents residing on 200 unit had the potential to be affected by		
	closed and latc	hed into the door			this deficiency.		
	frame. This de	ficient practice			The facility Maintenance Director or		
	could affect an	•			designee will complete a "Interior		
	residents on th	•			Room Door Inspection" (Attachment		
	. colucito di til	200 Ham			A) for each resident room by		
	 Findings instal	lo:			9/20/12.		
	Findings includ	ie.			The QA tool titled "Life Safety		
					Review" (Attachment B) will be		
	Based on obser	vation with the			completed by the Maintenance		
	Environmental	Supervisor on			Director or designee 2x weekly for 2		
	08/21/12 at 12	2:08 p.m., the			weeks, weekly for 2 weeks and monthly thereafter to ensure proper	•	
	corridor door t	o resident room			working order of our resident room		
	214 failed to la	itch into the door			door latches. Any issues will be		
	frame. This wa	as acknowledged by			logged on the QA summary log to be	2	
		ntal Supervisor at			discussed at the monthly QA		
	the time of obs				meetings.		
	the time of obs	ervation.			Corrective action will be complete		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet Page 4 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155321		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI 08/21				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	3.1-19(b)	,		by 9/20/12				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 5 of 16

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	01	COMPL	ETED
		155321	A. BUII B. WIN			08/21/	2012
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				STATE BLVD		
MILLERIS	MERRY MANOR				NAYNE, IN 46815		
			_		, IIV 40010		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029	NFPA 101	DE 07411D4DD					
SS=E	LIFE SAFETY CO						
		ed construction (with ¾ ors) or an approved					
		inguishing system in					
		8.4.1 and/or 19.3.5.4					
		us areas. When the					
	approved automa	itic fire extinguishing					
		used, the areas are					
	•	ther spaces by smoke					
		s and doors. Doors are					
	•	ion-rated or field-applied					
	protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1						
	Based on obse		K00)29	К029		09/20/2012
		acility failed to			The doors between the kitchen and	I	
	ensure 2 of 4 c	•			lobby will be equipped with latching hardware before 9/20/12.		
	_	tchen, a hazardous			Any resident in the lobby area had		
	area, were prov				the potential to be affected by this		
	closing devices	causing the door			deficiency.		
	to automaticall	y close and latch			The QA tool titled "Life Safety		
	into the door fi	rame. This			Review" (Attachment B) will be		
	deficient practi	ce could affect			completed by the Maintenance		
	residents in the				Director or designee 2x weekly for 2		
	residents in the	a 1000y1			weeks, weekly for 2 weeks and		
	Finalinana inalisa	la.			monthly thereafter to ensure prope working order of the new latches.	ſ	
	Findings includ	ie.			Any issues will be logged on the QA		
					summary log to be discussed at the		
	Based on an ob	servation with the			monthly QA meetings.		
	Environmental	Supervisor on			Corrective action will be complete		
	08/21/12 at 12	2:22 p.m., the two			by 9/20/12.		
		the kitchen from					
	the main lobby lacked latching hardware and failed to latch into the frame. Based on an interview						
	with the Enviro	nmental Supervisor					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 6 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155321		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/21/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	door were equ	observation, the ipped only with ch were locked when s not in use.						
	3.1-19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet Page 7 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPI	
		155321	B. WIN			08/21	/2012
NAME OF D	ROVIDER OR SUPPLIER		_	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
					E STATE BLVD		
MILLER'S	MERRY MANOR			FOR	T WAYNE, IN 46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0038 SS=E	NFPA 101 LIFE SAFETY CC	DE STANDARD					
33-E		anged so that exits are					
		e at all times in accordance					
	with section 7.1.	19.2.1					
	Based on obser	vation and	K00)38	К038		09/20/2012
	interview, the f	acility failed to			Codes were posted on all exit doo	rs	
	ensure the mea	ans of egress			on 8/27/12. All residents had the potential to be	10	
	through 4 of 6	exits were readily			affected by this deficiency.	ic .	
	accessible for r	esidents without a					
	clinical diagnos	sis requiring			Review" (Attachment B) will be		
	specialized security measures. LSC 19.2.2.2.4 requires doors				completed by the Maintenance		
					Director or designee 2x weekly for	2	
	within a require	ed means of egress			weeks, weekly for 2 weeks and monthly thereafter to ensure		
	shall not be eq	uipped with a latch			security codes remained posted a		
	or lock that req	uires the use of a			each facility exit. Any issues will b		
	tool or key fron	n the egress side.			logged on the QA summary log to	be	
	Exception No. 1	1 requires			discussed at the monthly QA		
	door-locking a	rrangements			meetings. Corrective action will be complete	Ч	
	without delayed	d egress shall be			by 9/20/12.	u	
	permitted in he	ealth care					
	occupancies, o	r portions of health					
	care occupanci	es, where the					
	clinical needs o	of the residents					
	require speciali	ized security					
	measures for th	neir safety,					
	provided staff o	can readily unlock					
	such doors at a	all times. This					
	deficient practi	ce could affect all					
	of the resident	room halls and					
	therefore affect	ts 52 resident.					
	Findings includ	le:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet Page 8 of 16

	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155321	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 08/21/2012				
	PROVIDER OR SUPPLIER S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				
	Based on observation with the Environmental Supervisor on 08/21/12 during the tour from 12:10 p.m. to 1:30 p.m., the emergency exit doors in the 100, 200 and 300 halls as well as the 200 hall nurses' station were magnetically locked and could be opened by entering a code, but the code was not posted. Based on an interview with the Environmental Supervisor at the time of observations, the facility does not take residents having a diagnoses requiring specialized security measures. This was confirmed by the Administrator at 1:45 p.m. during the exit conference 3.1–19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 9 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	01	COMPL	ETED
		155321	A. BUII B. WIN			08/21/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				STATE BLVD		
MILLEDIC	MERRY MANOR				NAYNE, IN 46815		
WILLER	NIERKI WANOK			FORT	WATNE, IN 40015		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0064	NFPA 101						
SS=E	LIFE SAFETY CO						
	Portable fire extinguishers are provided in all health care occupancies in accordance with						
		6, NFPA 10	17.00	VC 4			00/20/2012
	Based on observation and interview, the facility failed to		K00	J04	K064 The fire extinguisher on	0	09/20/2012
					the200 unit was replaced with fully charged extinguisher on	а	
	ensure 1 of 3 f	ire extinguishers			8/23/12. All residents residing	on	
	located in the 2	200 hall was			the 200 unit had potential to be		
	provided maintenance when the gauge on the fire extinguisher indicated it needed recharging.				affected by this deficiency. Th		
					QA tool titled "Life Safety Revi		
					(Attachment B) will be completed		
					by the Maintenance Director or		
		lard for Portable			designee 2x weekly for 2 weeks,		
	Fire Extinguish	ers, in Section			weekly for 2 weeks and monthly thereafter to ensure that each fire		
	4-4.1 requires	fire extinguishers			extinguisher is fully charged a		
	to be subjected	to maintenance no			in proper working order. Any		
	-	year apart or when			issues will be logged on the QA	Α	
	specifically ind				summary log to be discussed at		
	· ·				the monthly QA		
	•	is deficient practice			meetings. Corrective action will be completed by 9/20/12.		
	could affect 26	residents in the					
	200 hall.						
	Findings includ	le:					
	. 3						
	Raced on an ob	servation with the					
	Environmental	•					
	08/21/12 at 12	2:17 p.m., the					
	gauge on the p	ortable fire					
	extinguisher lo	cated near resident					
	room 201 indic						
	extinguisher ne						
	recharged. Thi						
	acknowledged	by the					
	Environmental	Supervisor at the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet Page 10 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155321			LDING	NSTRUCTION 01	(X3) DATE COMPI 08/21	LETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	time of observa	ation.						
	3.1-19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 11 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155321	B. WIN	G		08/21/	2012
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					STATE BLVD		
MILLER'S	MERRY MANOR			FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
K0076 SS=E	NFPA 101 LIFE SAFETY CO	DDE STANDARD				ļ	
00 L		age and administration				ļ	
		ed in accordance with					
		ards for Health Care				ļ	
	Facilities.					ļ	
	(a) Oxygen storag	ge locations of greater than				ļ	
		nclosed by a one-hour				ļ	
	separation.					ļ	
	(b) Locations for s	supply systems of greater				ļ	
	` '	are vented to the outside.					
	NFPA 99 4.3.1.1.	2, 19.3.2.4				ļ	
	Based on obse	rvation and	K00	076	К076	ļ	09/20/2012
	interview, the f	acility failed to			On 9/12/12 a 6 inch by 14 inch vent		
	ensure 1 of 1 a	reas used for			was installed in our exterior oxygen storage (Vent Pic1, Vent Pic2). This	ļ	
	transferring of	oxygen were			will provide an additional 84 square	ļ	
	provided with v	ventilation. This			inches of ventilation to the outside.	ļ	
	deficient practi	ice could affect 18			All residents residing on the 300	ļ	
	resident evacua	ated through the			unit had potential to be affected by	,	
	300 hall exit d	oor near the nurses'			this deficiency. The QA tool titled "Life Safety		
	station.				Review" (Attachment 1) has been		
					updated to review the oxygen	ļ	
	Findings includ	le:			storage shed ventilation and will be		
					completed by the Maintenance	_	
		rvation with the			Director or designee 2x weekly for 2	2	
	Environmental	Supervisor on			weeks, weekly for 2 weeks and monthly thereafter to ensure the		
	08/21/12 at 1	1:55 a.m., the			ventilation system is free from any		
	oxygen transfil	lling/storage			blockage and in proper working		
	enclosed plasti	c shed containing			order. Any issues will be logged on		
	five large liquid	d oxygen containers			the QA summary log to be discussed	1	
	was not vented	I to the outside.			at the monthly QA meetings.		
	This was confir	med by the					
	Environmental	Supervisor at the					
	time of observa	· ·					
						ļ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 12 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155321	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMPI 08/21	LETED	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	3.1-19(b)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 13 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01		01	COMPLETED		
	155321		B. WING		08/21/2012		
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				STATE BLVD		
MILLERIS	S MERRY MANOR				WAYNE, IN 46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0144	NFPA 101	DE 07411D4DD					
SS=F	LIFE SAFETY CO						
		spected weekly and oad for 30 minutes per					
		nce with NFPA 99.					
	3.4.4.1.	nee warra 1700.					
	Based on obser	rvation and	K01	144	 K144		09/20/2012
	interview, the f				The generator annunciator panel		
		-			was immediately reset on 8/21/12.		
	_	generators was in			All residents could have been		
		h NFPA 99, 1999			affected by this deficiency.		
	*	rd for Health Care			The QA tool titled "Life Safety		
	Facilities. NFP	A 99, Section			Review" (Attachment B) will be		
	3-4.1.1.15 req	uires a remote			completed by the Maintenance		
	annunciator to	be provided in a			Director or designee 2x weekly for 2	2	
	location readily	observed by			weeks, weekly for 2 weeks and		
	-	onnel at a regular			monthly thereafter to ensure the		
		NFPA 101, Section			generator annunciator panel is in		
	4.6.12.1 requir				proper working order. Any issues will be logged on the QA summary		
	•	•			log to be discussed at the monthly		
		system required for			QA meetings.		
	compliance with the provisions of the Code shall be continuously maintained in accordance with applicable NFPA requirements. NFPA 72, National Fire Alarm				Generator annunciator panel is also		
					checked every Thursday by the		
					Maintenance Director or designee		
					and recorded in the TELS Logbook		
					Report System.		
	Code, in 7-4.3				Corrective action will be completed		
		iring resetting to			by 9/20/12.		
		al operations shall					
		·					
	-	mptly as possible					
		and alarm. This					
	deficient practi	ce could affect all					
	occupants.						
	Findings includ	le:					
					-		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet Page 14 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION O1		(X3) DATE SURVEY COMPLETED		
155321				LDING		08/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					STATE BLVD		
MILLER'S MERRY MANOR				FORT V	VAYNE, IN 46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		vation with the		IAG	,		DATE
	Environmental						
	08/21/12 at 12	•					
		vas silenced and a					
		ndicator red light					
	was flashing or	-					
	_	nel located at the					
	-	ation. Based on an					
		the Environmental					
	Supervisor who placed a phone						
	call to the Maintenance Director at the time of observation, he						
		the generator and					
	forgot to return the generator transfer switch to the automatic						
	mode when fin						
	Maintenance D						
		enerator would					
	automatically start in an						
	-	m manual mode. It					
	was then point						
	surveyor that if						
	develop with th	•					
	preventing the	• .					
	•	annunciator panel					
	=	d with blinking red					
	-	event the facility					
	from being ma	de aware of the					
	problem.						
	3.1-19(b)						
	3.1 - 1 3(D)						

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Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 15 of 16

PRINTED: 09/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	INTO PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155321	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMI	E SURVEY PLETED 1/2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5544 E STATE BLVD FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETION		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XNIM21

Facility ID: 000214

If continuation sheet

Page 16 of 16